SELECT JOINT COMMISSION ON MEDICAID OVERSIGHT

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MEETING MINUTES[1]

Meeting Date: October 4, 2007
Meeting Time: 10:00 A.M.
Meeting Place: State House, 200 W. Washington St., Senate Chambers
Meeting City: Indianapolis, Indiana
Meeting Number: 4

Members Present: Sen. Patricia Miller, Chairperson; Sen. Robert Meeks; Sen. Ryan Mishler; Sen. Sue Errington; Sen. Vi Simpson; Sen. Connie Sipes; Rep. Charlie Brown; Rep. William Crawford; Rep. Peggy Welch.

Members Absent: Rep. Timothy Brown; Rep. Don Lehe; Rep. Suzanne Crouch.

Sen. Miller called the fourth meeting of the Select Joint Commission on Medicaid Oversight to order at approximately 10:10 a.m.

Physician Reimbursement

Dr. Jeffrey Wells, Director of the Office of Medicaid Policy and Planning (OMPP), provided a three-page document summarizing OMPP's plans for increasing physician reimbursement in the Medicaid program (Exhibit #1).

Dr. Wells explained that the reimbursement plan includes two bonus payments along with a permanent fee increase. The first bonus payment to be made in state fiscal year (FY) 2008 uses $10 million in state Medicaid funding carried over from FY 2007 and is prioritized for primary and preventative care services provided by family practitioners, general practitioners, obstetricians/gynecologists, general internists, and general pediatricians. Approximately 70% of the bonus payment ($18.7 million in state and federal funds) will be distributed through managed care organizations (MCOs) and 30% ($8 million in state and federal funds) through the fee-for-service system .

[1] Exhibits and other materials referenced in these minutes can be inspected and copied in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for copies may be mailed to the Legislative Information Center, Legislative Services Agency, 200 West Washington Street, Indianapolis, IN 46204-2789. A fee of $0.15 per page and mailing costs will be charged for copies. These minutes are also available on the Internet at the General Assembly homepage. The URL address of the General Assembly homepage is http://www.in.gov/legislative/. No fee is charged for viewing, downloading, or printing minutes from the Internet.

An estimated 3,800 managed care physicians will benefit with an average increase in payments of $4,929 and a median increase of $1,907. Payments are planned for December 2007.

An estimated 5,500 physicians in the fee-for-service system will benefit with an average increase in payments of $1,467 and a median increase of $723. Payments will be made as soon as possible after receiving approval for the Medicaid State Plan amendment from the Centers for Medicare and Medicaid Services (CMS).

Because many physicians provide services through both the managed care system and the fee-for-service system, OMPP estimates that approximately 7,000 different physicians will see an average bonus payment for FY 2007 of $5,000. However, the range of payment to physicians will vary significantly based on the individual physician's participation in the program.

A second bonus payment for the first half of FY 2008 will use approximately $4.6 million in state funds from the funding generated by HEA 1678-2007. A process similar to that described above will be used to distribute approximately $12.4 million in state and federal funds to physicians. Payments should be completed in the first quarter of calendar year (CY) 2008 for managed care physicians with payments to fee-for-service physicians by the end of FY 2008.

A permanent increase in physician reimbursement will use approximately $4.6 million in state appropriations from HEA 1678 and about $2.6 million from the Hospital Care for the Indigent (HCI) tax levy. This will result in additional managed care payments of $13.5 million and $5.8 million in fee-for-service payments (state and federal funds). Payments are expected to begin in January 2008.

In addition to the physician reimbursement increases, OMPP is planning a dental fee increase using $4.6 million in state funds to generate a total of $12.4 million in total additional funding. The state share will come from the funding generated by HEA 1678. Payments are expected to begin in January 2008.

OMPP also intends to use approximately $0.4 million in state funds from the HCI levy to generate about $1 million in state and federal reimbursement for Medicaid transportation providers. Payments are expected to begin in January 2008.

Sen. Miller requested from OMPP additional information on the formula and the codes used for the reimbursement changes.

Responding to a question as to how the state will know that each provider receives the increase, Dr. Wells indicated that for the bonus payments, there will be an audit trail and a requirement imposed on the MCOs to pass the payments on to the physicians.

EDS and MCO Providers' Claims Payment and System Access Reports

Dr. Wells indicated that there was no report from EDS at this meeting, and the MCOs would be reporting during the next agenda item. Sen. Miller requested that the EDS report be presented at the next meeting and as a regular agenda item.

MCO Behavioral Health Contracts for Hoosier Healthwise

Dr. Wells introduced the topic of MCO Behavioral Health Contracts with a slide presentation (Exhibit 2). Dr. Wells also handed out two documents: *Select Physical Health Measures for Dashboard Report for Q3 2006 - Q2 2007 Hoosier Healthwise Program* (Exhibit #3) and *Select Physical Health Measures for Dashboard Report for Q1 - Q4 2007 Hoosier Healthwise Program* (Exhibit #4).

Dr. Wells stated that prior to January 2007, most behavioral health and substance abuse treatment for Indiana Medicaid and Children's Health Insurance Program (CHIP) members was part of the traditional fee-for-service system, regardless of membership in an MCO. The state's goals in "carving in" behavioral health were to provide more holistic care, increase communication between the primary medical provider, MCO, and behavioral health providers, and to better manage utilization of behavioral health services.

Dr. Wells described the reasons for using managed care for behavioral health as the following: (1) to provide a medical home from which all types of needed care can be coordinated, provided, and managed; (2) to provide increased coordination between medical and behavioral health service providers; (3) to provide that MCOs and managed behavioral health organizations (MBHOs) accept financial risk to develop and manage networks and deliver covered services; (4) to increase member options and choice of services; and (5) to decrease care fragmentation.

Dr. Wells also discussed the following, with additional information provided in Exhibit #2: (1) managed care tools; (2) access to care; (3) the medical management decision process; (4) prior authorization (PA) requirements; (5) behavioral health drugs; (6) managed care challenges; (7) common claims issues; (8) and a comparison of MCO behavioral health contracts data.

Sen. Meeks asked why one of the three MCOs was so different from the other two in terms of average length of stay, timeliness of provider payments, and in the denial of service. Dr. Wells stated that he had no explanation for some the data in the reports, but the state clearly has responsibility and is working to get more data and information from the MCOs. Dr. Wells indicated that the denials are focused on the inpatient setting.

Responding to a question as to why services for post-partum depression are cut off at 60 days, Sec. Mitch Roob stated that this is because of a woman's eligibility for Medicaid due to her pregnancy status and that it will be addressed by the Family Planning Waiver, which has had a delayed implementation.

Members requested a bill draft from LSA to require the same time frame for an MCO or subcontractor to make a clean claim payment as is currently required of OMPP.

Responding to a question as to who is responsible for resolving the managed care challenges in providing behavioral health services described on page 9 of the slide presentation handout, Dr. Wells indicated that, ultimately, he is responsible, but that he also wants to discuss what OMPP is doing to ensure good outcomes. Dr. Wells added that they can look at claims data to see how effective care delivery is under the program. Members requested that the issue of measures of care be placed on the next meeting's agenda.

Members stated concerns about a lack of uniformity in care between MCOs as well as between fee-for-service and risk-based managed care recipients, and requested that data be tracked and the information provided at the next meeting regarding the number of denials, the average length of stay, and peer-too-peer evaluations.

Sen. Miller stated that she would coordinate with the chairperson of the Mental Health Commission so as not to duplicate review of this issue. Sen. Miller opened the floor for public testimony.

Ms. Cindy Peterson, Cenpatico Behavioral Health, the MBHO for Managed Health Services (MHS), stated that Cenpatico has been providing inpatient behavioral health services in Indiana since 2003. Their length of stay (LOS) for adults and children has averaged 4.7 days, while

LOS for children has averaged 5.7 days. However, more importantly, their readmission rate has decreased to less than 10%. Ms. Peterson added that it is their goal to provide services in the least restrictive environment, so the inpatient LOS statistics are not always the most appropriate measure to use as an outcome measure. She added that there is significant variation in LOS between hospitals across the state.

Members requested data to be provided to substantiate the comparison information provided in Dr. Well's slide presentation, data on rates of denials in doctor-to-doctor authorization procedures, denial data broken down by the steps in the appeals process, and state-to-state comparison data.

Ms. Tina Berkeley, Magellan (MBHO for Anthem), stated that over 95% of their claims are adjudicated within 10 days. Ms. Berkeley added that there are problems with billing technicalities, but that this is going better than what is sometimes heard. Regarding access to care, there is only one county in Indiana with less than 100% access, and they have received no complaints regarding access.

Mr. Steve Young, Magellan, cautioned the Commission that LOS data is only one piece of the total information; readmission rates were much more important. Mr. Young added that there are also reasons to celebrate: (1) coordination of care is now occurring between the physical health system and the mental health system; (2) there is ambulatory followup on discharge plans; and (3) there is now more coordination between the providers and the MCOs.

Mr. Jim Jones, Indiana Council of Community Mental Health Centers, stated that there has, in fact, been a "rough rollout" to the managed behavioral health system, which has been even more challenging with Medicaid growth being held to 5%. Mr. Jones added that moving to a managed care process presents other challenges; one assumption was that the cost associated with contracting was estimated as 18% of the cost of services, and the 18% has to be made up by fewer services. This implies a $9 million reduction in services. The two cost containment tools permitted to MCOs is prior authorization and utilization, which leads to fewer people receiving services and less care provided to patients.

Mr. Jones made three suggestions: (1) assure that the business plan model is not overly tipped to the profit side; (2) standardize protocols between MCOs, which is not the case now; and (3) have a greater integration of behavioral health with primary care. Mr. Jones stated that it is his hope that we can have a managed care program rather than a managed resource program.

Ms. Pat McGuffey, representing Indiana Psychological Association, stated that her association's experiences with the managed care organizations have been quite negative regarding the following: (1) denial of authorization of assessments and testing; (2) denial of authorization of treatment; (3) denial of authorization of the number of visits; and (4) the time and cost of administrative demands, such as the time spent on hold on the telephone and the increased amount of time spent on requirements that are not reimbursed.

Ms. Michelle Brochu, Comprehensive Behavioral Care (MBHO for MDwise), stated that the MCOs have been meeting behind the scenes to address the concerns expressed by the Commission and with the goal of providing good care and services in Indiana.

Other Business

Rep. Crawford stated that he has made repeated requests for information from FSSA regarding the Medicaid Early Prevention, Screening, Diagnosis, and Treatment (EPSDT) services and that he hopes that all of his requests will be fulfilled by the next meeting. Otherwise, Rep. Crawford stated that he would be filing a complaint under the Access to Public Records law. Dr.

Wells indicated that his office is working on the requested information. Rep. Crawford added that he would like for the requested information to be distributed to all members of the Commission.

Sen. Miller announced that the next and final meeting of the Commission, scheduled for October 29, would commence at 9:00 a.m. rather than 10:00 a.m. Sen. Miller also announced that the agenda items that were not covered today would be added to the agenda of the next meeting.

The meeting was adjourned at approximately 12:25 p.m.